

A guide to capturing and using patient, public and service user feedback effectively

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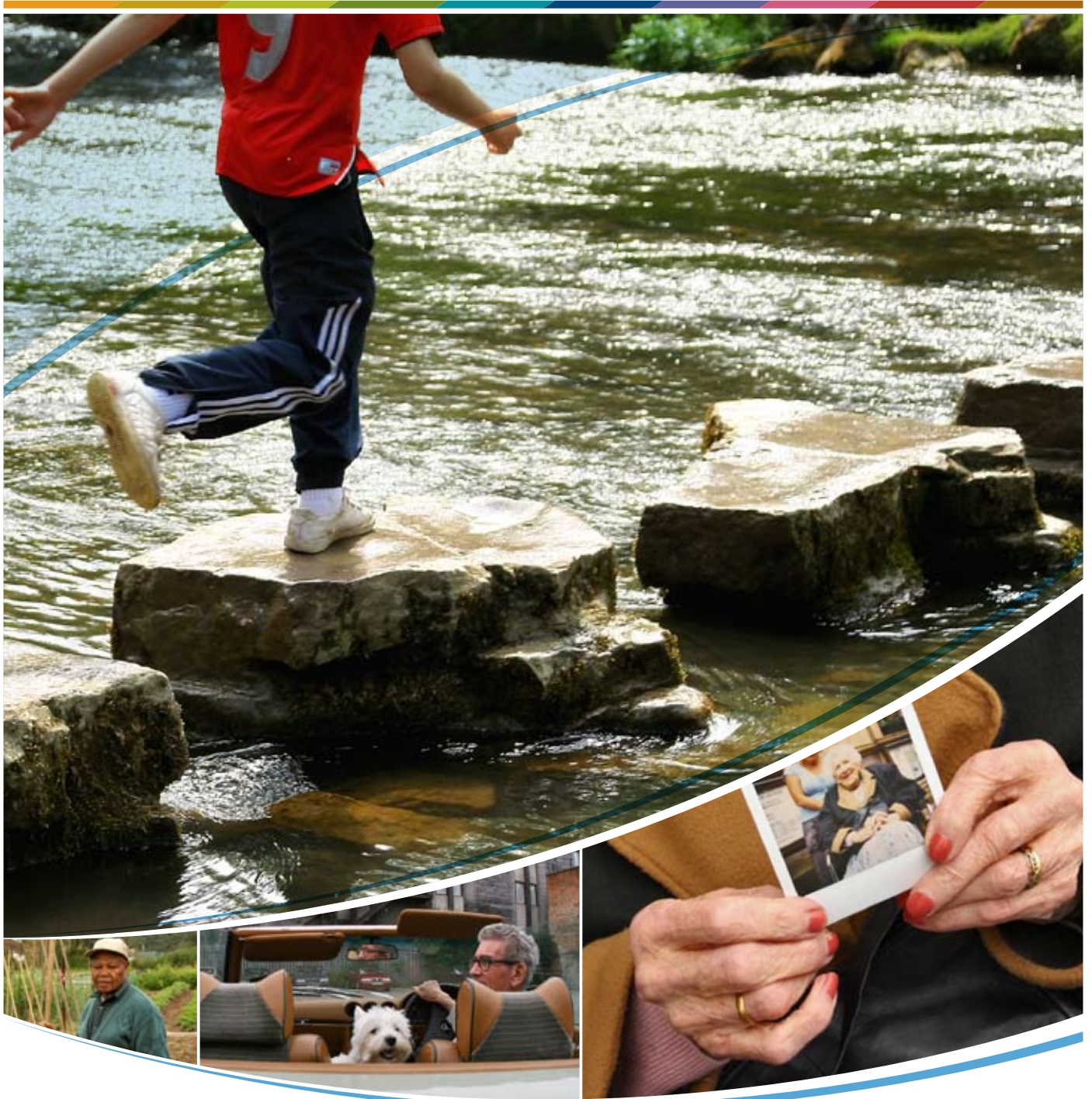
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A guide to capturing and using patient, public and service user feedback effectively



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1.0

Foreword

The “Once in a Lifetime Review” conducted by Lord Darzi includes the statement

“Effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to patient needs and choices being led by clinicians, taking account of the best available evidence”¹

However, ensuring the differing views of patients, the public and service users are collected appropriately and used effectively to drive service design, redesign or commission new services is a considerable challenge for PCTs and Trusts.

The recent World Class Commissioning Assessment in the West Midlands, and research undertaken by the Health Services Management Centre² locally shows that PCTs and Trusts are keen to improve their performance in this area. However, it is also clear that many organisations

are using patient experience feedback on an ad hoc basis and that its use is not yet systematic.

This Guide has been produced as part of Investing for Health Project 4 to assist PCTs, Practice Based Commissioners and Trusts with the effective commissioning, analysis and use of patient, public and service user feedback. It highlights the need for engagement to be meaningful, embedded within each organisation and understood and valued by staff. It gives a simple guide to each of the different methods for collecting feedback, as well as top tips, case studies and useful resources.

I believe this guide will be useful to all who want to adopt a more systematic approach, ensuring continuous service improvement by being more responsive to patients and service users.

Jo Chambers,
Chief Executive,
Shropshire County PCT & IfH Project 4 Chair

¹ High Quality care for All. NHS Next Stage Review Final Report, June 2008, Lord Darzi

² Davidson D, Brown H, Brown H. Real-Time Patient Experience Feedback in the West Midlands



2.0 Introduction

NHS West Midlands has commissioned this guide primarily in order to assist Primary Care Trusts, Practice Based Commissioners with the effective commissioning, analysis and use of patient, public and service user feedback. However it will also be of use to NHS Trusts who are concerned with the effective capture and use of patient and service user feedback. It follows a study previously commissioned from the Health Services Management Centre at the University of Birmingham on the use of real-time methodologies and technologies to capture feedback, within the West Midlands. (Brown et al 2009)

This study was commissioned for a number of reasons as follows:

- Patient experience feedback is moving centre stage in policy terms. In 2008/9 it featured in all 4 leading documents on Health Policy (NHS Constitution, The Operating Framework, World Class Commissioning and High Quality Care for All)
- The collecting of feedback is growing but there is concern organisations are not managing this in a systematic way and that much work is ad hoc
- While the use of feedback to drive service improvements is established, the use of feedback to influence commissioning decisions is not so well advanced
- The extent of usage of real-time technologies was unknown and its place within an organisation's overall engagement strategy unclear
- No clear guidance on best practice for real-time methodologies exists.

Information provided within this guide comes from a variety of sources including the Department of Health, the Healthcare Commission, Local Government, academic literature, questionnaires and interviews with healthcare organisations and suppliers of goods and services.

Who is this guide aimed at?

This guide has primarily been developed for PCT commissioners, Patient and Public Engagement and Involvement Leads and their teams, Communication Leads and their teams, and those responsible for knowledge management within PCTs. However it will also be of use to those concerned with planning, undertaking, and analysis of individual patient/service user feedback within NHS Trusts.

The guide will also benefit PCT Board members, as those accountable under Section 242 (1B) of the NHS Act 2006, which now requires NHS organisations not only to gather patient views, but also to demonstrate how these have influenced decisions.

What is it for?

This guide sets out the issues that organisations should be aware of in respect of capturing and using patient, service user and public feedback effectively. It is not intended to answer every question practitioners may have about the practicalities of conducting engagement or involvement activities as there is already a significant body of material available on these matters from other sources.

What are the benefits to organisations of engaging with people?

For the last 10 years, the notion of the citizen-consumer has been central to evolving government policies, in order to achieve its vision for world class public services and a fairer society.

Involving people can have an effect on how services are planned, organised, delivered and importantly how they are used. This in turn can have a positive effect on care outcomes as effective engagement can increase confidence and trust in services, can help people understand health conditions and treatments better and can make services more responsive to people's needs.

What does current NHS policy say about engagement?

How does engagement fit into World Class Commissioning?

The Department of Health's vision for World Class Commissioning (WCC) is that it will deliver better outcomes and better value by providing people with more choice and control over the services they use. Competency 3 within the WCC framework requires PCTs to develop continuous and meaningful engagement with the public, patients and service users in order to shape services. (DH 2007)

What does Darzi's Next Stage Review say about engagement?

The High Quality Care for all report (DH 2008) states that patients will be able to increase their influence over NHS resources and recommends that changes to services should be transparent, locally-led and for the benefit of patients.



What are providers expected to do in terms of collecting feedback?

In September 2008, Alan Johnson, the Secretary of State for Health, made an announcement in which he called for a more patient-centred NHS. He announced that within 12 months every hospital trust will be expected to collect immediate feedback on hospital care in order to know within two weeks of treatment how patients felt about their care. The implication in this policy announcement is that real-time or near-to-real-time feedback will be a mechanism for providers to collect data to demonstrate this and to improve the quality of existing services. SHAs are working on an assumption that this data will also be used by PCTs for contract negotiations and to drive commissioning decisions.

What does the NHS Constitution say about engagement?

The NHS Constitution (DH 2009a) states that people have a right to be involved in the planning of healthcare services and in decisions about changes to those services.

What are PCTs expected to do under the 2009 Operating Framework?

Improving the patient experience is one of the five priorities set in the previous Operating Framework and which continue for 2009/10. The Framework also reminds organisations of their legal obligations to involve and consult patients and the public, as set out in the Department's Real Involvement document (2008b), and highlights the need to develop a strong relationship with Local Involvement Networks (LINKs).

The Framework notes that commissioners and providers should work in partnership, "...to implement systems that respond to the views and experiences of patients and improve the patient experience of services." (DH 2008c) The Framework suggests that real-time or near-to-real-time feedback will give providers and commissioners the opportunity to be more responsive in improving the patient experience.

How will PCTs judge how well they are doing in terms of engagement?

The performance of NHS organisations is assessed against the Standards for Better Health framework (DH 2004). Within the framework, core standard 17 (C17) states: "The views of patients, their carers, and others are sought and taken into account in designing, planning, delivering and improving health care services". Developmental standards 8 and 11 respectively state 'Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives,' and 'Health care organisations plan and deliver health care which reflects the views and health needs of the population serviced'.

Before closing, the Healthcare Commission published a report on how well organisations were engaging with people to plan and improve services. It found that though 98% of organisations stated they met C17 (2007/08 annual health check), 25% of comments about that standard from patient forums and Overview and Scrutiny Committees were negative. (Commission for Healthcare Audit and Inspection 2009)

The National Institute for Health and Clinical Excellence (NICE) has also published guidance on engagement within the NHS (NICE 2008), setting a quality benchmark for all organisations to meet.

What advice does The National Centre for Involvement give organisations?

The National Centre for Involvement undertook two studies, one in 2007 and one in 2008 to determine the current state of patient and public involvement in the English NHS. The research indicated that though progress had been made, there was much still to do. The main issues affecting organisations were a lack of top level managerial and clinical commitment and a lack of resources to conduct involvement and engagement adequately.

The centre also suggests the following principles should be adhered to in order that involvement and engagement activities achieve maximum effectiveness:

- Organisations must be clear about the purpose for involvement and should focus on it as a means of improvement
- Organisations must take a systematic approach, linking corporate decision-making to the community's opinions and views





- Organisations must be honest about what can and can't change
- Organisations must demonstrate change as a result of involvement and must provide feedback to people about what has been learned and what actions will be taken
- Opportunities for people to be involved must be promoted and a variety of methods offered
- A concerted effort should be made to include people whose voices are seldom heard
- Information and knowledge must be shared to ensure people understand the issues and can make a worthwhile contribution
- Staff must have the necessary skills to undertake involvement and to act upon the results.

What is the rest of the public sector doing?

Local Government is working through similar issues to healthcare in terms of engagement and involvement, with a new duty on local authorities to promote democracy and embed empowerment. Public Service Agreement 21 requires local authorities to increase the number of people who feel able to influence local decisions. (Dept of Communities and Local Government 2007)

Local Strategic Partnerships (LSPs), which include healthcare organisations, will be required to demonstrate how such engagement results in better health and care outcomes for people.



3.0

How gathering feedback fits into the wider context of engagement

The gathering and use of feedback to make changes or improvements to services, is only one part of engaging with patients, service users and members of the public. There are a number of helpful models that explain the place of feedback within the overall context of engagement.

Dimensions of public and patient involvement

The model below, shows that activity can be aimed at the individual or collective level and that this may take the form of: providing information; providing opportunities to give feedback, and for this to be acted upon; or involving people i.e. in co-designing services or determining spending priorities etc. Different methodologies and

activities would populate each box as examples of the dimension of engagement i.e. a newsletter distributed to every householder may be placed within the informing at the collective level box, whereas a patient story intervention may be classed as feedback at the individual level.

	Inform	Feedback	Involve
Individual	Email/letter	Patient story	Expert Patient Programme
Collective	Newsletter	Online community	Citizen's Jury

Fig. 1 Main dimensions of public and patient involvement

Source: *Signposts – A practical guide to public and patient involvement in Wales (2001)*

Arnstein's Ladder of Participation

Sherry Arnstein meanwhile developed an eight-step 'ladder' of citizen participation in planning processes where manipulation is the lowest rung and citizen control the highest, as follows:

Citizen control	Degree of citizen power
Delegated power	
Partnership	
Placation	Degree of tokenism
Consultation	
Informing	
Therapy	Non participation
Manipulation	

Fig. 2 Arnstein's Ladder of Participation
Source: *Arnstein (1969)*

This model can suggest however that practitioners should aspire to move up the ladder leaving earlier rungs behind, when in fact, different levels may be appropriate at different times and in different circumstances. Practitioners should also be aware that engagement in whatever form should not happen as a one-off but rather that it is both a continual and continuous process.

Embedding the use of feedback within organisations

The Department of Health has also produced guidance on the use of patient experience feedback to transform (DH 2009b). This model, which sets out a systematic approach to embed the use of feedback within an organisation, shows how the cycle starts with top level commitment and staff engagement and moves through leading by example during implementation, to celebrating achievements.

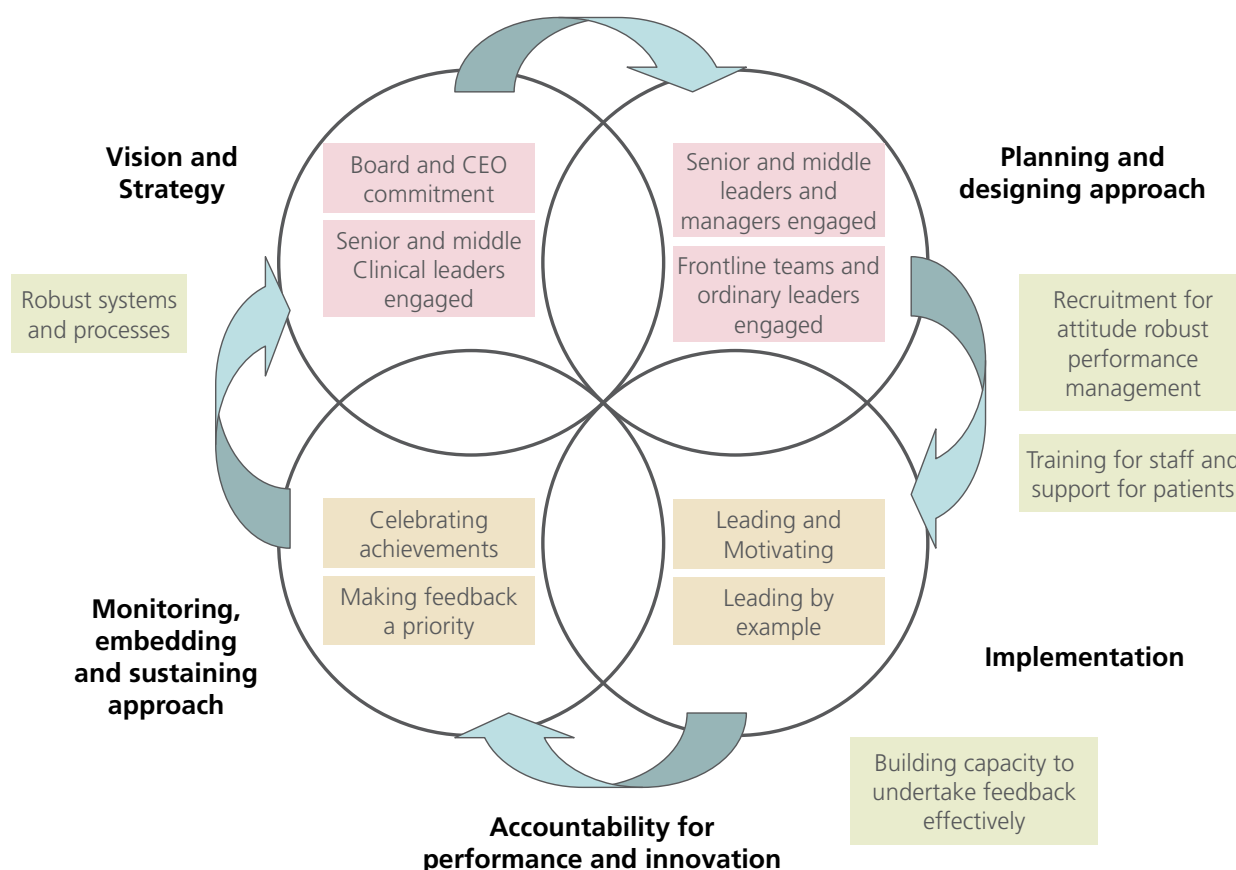


Fig. 3. How to embed the use of feedback within an organisation
Source: *Karen Ashton, Programme Director, NHS South Central*



4.0

Engaging people and collecting feedback

Response rates using all forms of research methodologies are falling. This may be due to a number of factors such as; consultation fatigue among local communities, public cynicism about the impact of involvement and a general decline in civic participation.

Methodologies

People's preferences for a feedback method will depend on the nature of the feedback and whether it is a complaint, a general comment or a suggestion. Some people will prefer to give feedback anonymously as they may worry giving negative feedback will compromise their future or ongoing care.

No one method will reach everyone in the community and no one method is suitable for or preferred by everyone. Organisations will need to think about the functional literacy and cognitive ability of respondents and consider whether translated materials, interpreters or advocates, visual or audio methods may be more suitable for people with low literacy, learning disabilities or sensory impairments.

Response rates also vary among different groups and are lower among older people, younger adults, people from black and minority ethnic (BME) communities, men, those in poor health, people with disabilities, people on low incomes, people who live alone and people with a lower level of education.

Low response rates are not only problematic in terms of data validity but can lead to bias if the views and experiences of those that do respond are likely to differ significantly from those of non-responders.

However, when asked, most people welcome the opportunity to provide feedback on their own experiences, in order to benefit others. Organisations can capitalise on this, providing they are committed to making change happen.

Organisations must be clear from the outset about the purpose for any engagement activity and where it fits into its overall strategy for patient and public involvement and engagement.

If the goal is to gather general information, to give everyone that wants it the opportunity to feed back, or to identify those who have had a poor experience of care, a brief questionnaire is normally sufficient. However, if the goal of an organisation is to measure quality with reliable and valid indicators, it will need to ensure its results are statistically significant by employing more robust methods of gathering data and achieving larger, representative samples. This applies equally to prospective and real-time methodologies.



Did you know?

16% of adults in the UK lack basic literacy skills, and 47% lack basic numeracy skills. (Department for Education and Skills, 2003)

Studies show that health information for patients and the public is written at an above average reading ability, making it difficult for many people to understand. (Coulter and Ellins, 2006)



5.0

Designing and undertaking survey feedback

What questions to ask

Often the focus and content of patient feedback surveys are determined by managers or researchers, rather than patients or service users. It's important however to consider what matters most to patients. Organisations should therefore involve patients and the public in determining what is important to them and therefore what should be measured, bearing in mind that just measuring satisfaction, which is a subjective concept, will not necessarily provide the sort of information an organisation can act on to bring about change.

Patient expectations and priorities change over time, so evaluation questions should establish whether the aspects of care that are addressed remain relevant and important to people over time.

Whatever questions are asked, a survey or questionnaire must be formally tested to ensure validity and reliability.

Who to ask

All survey methods suffer from self-selection to some degree or another and therefore different samples will produce different outcomes as the profiles of respondents will be different.

Organisations should use an Equality Impact Assessment (EIA) to understand the implications of using different methodologies for different groups of people.

When to ask

While immediate feedback is useful for driving service level improvements, the gathering of information on an ongoing basis and over a longer time-frame may be more suitable for strategic or commissioning decisions.

Some people will prefer to be asked retrospectively for their views on their experience of care as this can be less intrusive and allows time for reflection. Others are happy to be asked at the point of care, when their experience is fresh in their minds. Organisations may also wish to consider collecting feedback at several points during an individual's contact with services in order to highlight differences in experience at particular stages.

Providing people with choice not just as to the method of collecting feedback but also its timing is important.

If patients or service users are evaluating their care at the point of delivery, they will not always be able to comment on the full patient journey i.e. discharge arrangements, outpatient follow up appointments, district nursing care etc.



Pause for thought

Who within the organisation collects feedback, whether formal or informal, from patients, service users and members of the public? Who in the organisation is responsible for collating this information, analysing and disseminating it and ensuring appropriate actions are taken?

Who is responsible for collecting and using feedback

While most organisations already collect large amounts of feedback, this is not always collated or analysed systematically. Its use can therefore be ad-hoc rather than focused on a specific strategy.

Where the responsibility lies for gathering feedback and analysis, reporting and taking action needs to be clear and understood by all within the organisation.

Factors that influence the feedback people give

When people are asked to provide feedback or information to another person, as opposed to anonymously or by self-administered methods, they may provide the responses they think the 'researcher' wants. They are therefore less likely to provide either negative feedback on their experience of care or sensitive information such as drug taking habits or incidence of poor mental health. The presence of a 'researcher' may also lead people to think they are being evaluated in some way and therefore responses to questions may be more positive i.e. lower estimates of alcohol consumption or higher estimates of physical activity.

Patient evaluation of their experience can be influenced by factors such as gratitude, faith and luck so people may give positive evaluations, even when their care has been poor. This is particularly true of older people.

Real-time or point-of-care surveys also appear to produce more positive results than retrospective methods. There might be various reasons for this such as patients fearing a negative response could compromise their ongoing care, patients wanting to be optimistic about their care while they are receiving it and opinions about care not fully forming until later when people have had an opportunity to reflect and compare their experience with others.

Staff attitudes to patient and public feedback

The value of patient feedback is not universally acknowledged by staff, particularly clinicians. However real-time feedback can have greater credibility and validity among staff due to its immediacy. Staff can feel differently about feedback, especially if it is in the patient's own words, as it makes the information more 'real'. This in turn makes it easier for staff to be more responsive and to take responsibility for



making changes. However, this requires both a supportive environment from the organisation and a receptive attitude from staff, which may mean a significant culture change within many organisations.

The value of real-time or immediate feedback to organisations

It is difficult to determine over long periods of time what actions or interventions, have had an effect on changing performance, as other factors will undoubtedly come into play during the elapse of time. How well an organisation is

able to determine cause and effect will therefore depend in part on the time it takes from feedback collection, to analysis, and thence to action.

Real-time feedback provides organisations with an opportunity to increase their responsiveness to service users and the public by helping them address issues more quickly and preventing problems from either escalating or being experienced by others. It can therefore be used to drive quality and keep momentum going in service improvement programmes.

Real-time feedback also demonstrates an organisation's commitment to service user satisfaction and public opinion.

Pros and cons of using real-time methods and technologies

- ✓ Ease of use
- ✓ Staff attitudes – 'real' data = increased ownership and motivation
- ✓ Freshness of data – cause and effect easier to determine
- ✓ Perception of greater responsiveness by service users
- ✓ Prevent issues becoming problems and improve experience for others
- ✓ More likely to capture detail as not reliant on an individual's recall
- ✗ Some groups may find technological methods less easy to use i.e. older people, children, those with physical disabilities and those with learning disabilities
- ✗ Not reaching people who are not using services
- ✗ Purpose for using real-time feedback lacks clarity and is not linked to strategy
- ✗ Value of quantitative versus qualitative feedback
- ✗ Positivity of response bias
- ✗ Reflection is an important element of giving feedback when considering an experience in its entirety



6.0 Feedback methods and technologies – advantages and disadvantages

Research has shown that no one method of collecting feedback will reach every group within the community, and no one method of collecting feedback is suitable or preferred by everyone. Because of this organisations collecting patient feedback need to think very carefully about the nature of the service in question, the client group they are trying get feedback from and then choose the most appropriate feedback method to suit the circumstances.



Face-to-face interviews

Face-to-face methodologies include one-to-one interviews, such as patient stories, and focus groups.

Pros

- Most inclusive method as no technological barriers
- Qualitative method providing rich source of data
- People appreciate the human dynamic of face-to-face interaction
- Patient stories can be undertaken either reflectively or in real-time, or near-to-real-time terms
- The reasons 'why' issues are being raised can be explored in order to improve services
- Technology-based methods in comparison tend to only gather opinions and trends i.e. the 'what' in terms of issues

Cons

- Takes longer and produces fewer responses
- Requires an investment in training and administration
- Interviewer can have a moderating effect on responses

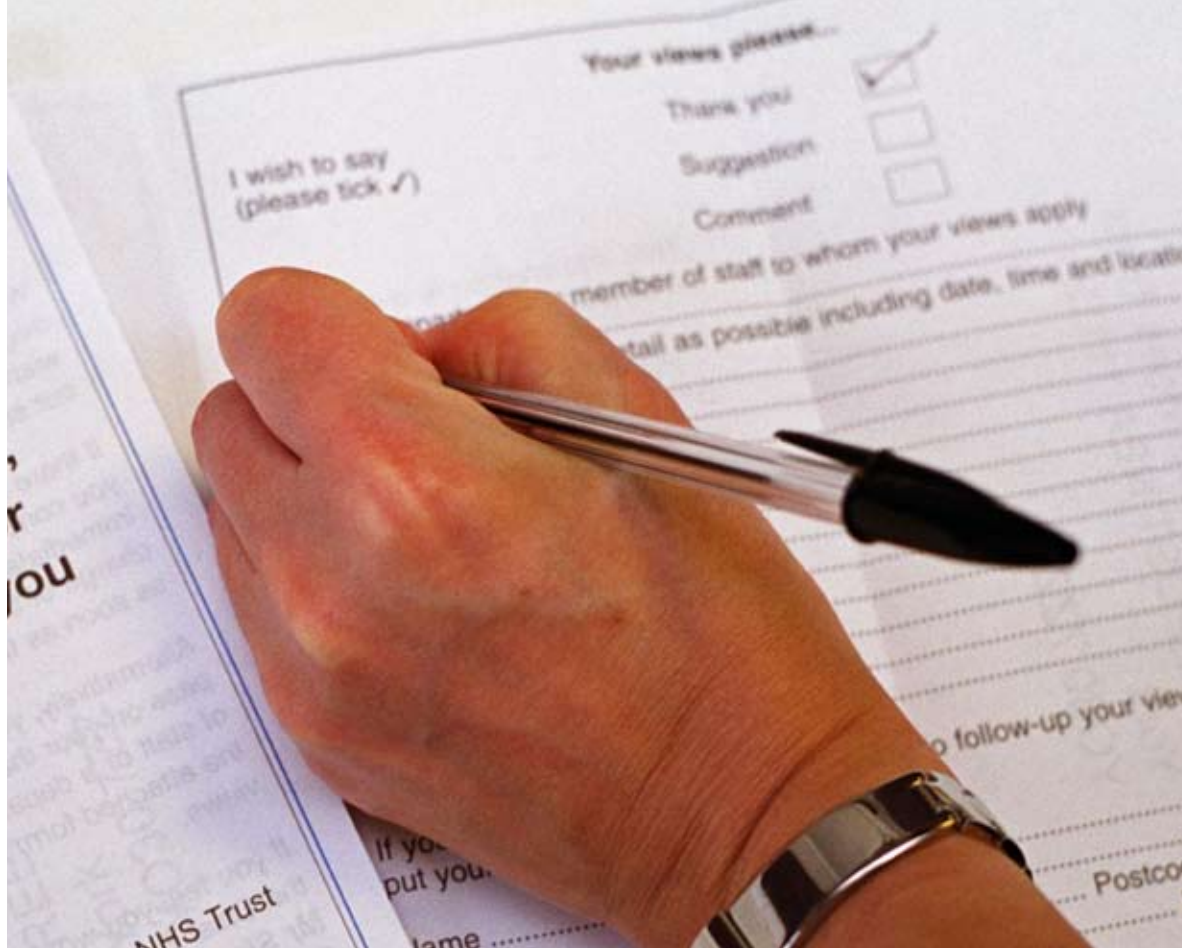
Case Study

A mental health trust in the West Midlands trains ex-service users to conduct exit interviews with older people who have received inpatient care. This approach has been welcomed by service users and may encourage a more honest level of disclosure than those interviews conducted by staff or others seen as associated with the organisation, including regular volunteers.



Fact

There is a strong link between the communicative aspects of care and patient satisfaction.



Paper-based methods

Paper-based methods may include pen and paper questionnaires, comment cards or feedback forms. Paper questionnaires normally provide respondents with either multiple choice type answers, or ask people to rate services, or experiences, on a numerical scale such as the Likert scale.

Pros

- Cheap, convenient and userfriendly
- Obtains large quantities of quantitative data
- When self-administered – produces higher reporting of 'undesirable behaviour' or sensitive information

Cons

- Use for qualitative data gathering is limited
- Postal questionnaires – poor and slow response rates
- Comment or feedback cards can result in mostly extreme responses i.e. the very good or the very bad

Case Study

A UK independent healthcare company which currently has 32 hospitals (31 in England and one in Scotland) uses a patient satisfaction sheet to gather feedback from inpatients. The sheet is handed to patients when they are admitted. A receptionist on the wards collects these before the patients go home, though patients can also complete the forms at home and post them back. All feedback forms are sent to a central collection point. They are then sent on to a third party for collation and analysis.

Fact

Postal questionnaires are still preferred by certain demographic groups such as older people, the less well educated and blue collar workers.



Hand-held devices

PDAs (personal digital assistants) are increasingly being used for gathering real-time feedback. These hand-held computers typically have a touch screen or soft keys for entering data and enable the downloading of data directly to a computer or through a phone line.

Pros

- Generally user-friendly for those using and administering them
- Flexibility to change questions though supplier may charge
- Produce high number of responses in short timescales
- Number of questions vary between devices – from 5 to 20+

Cons

- Representativeness and sample size within inpatient settings may pose challenges as sample determined by staff. This is based on ability to take part but may lead to 'difficult' patients being excluded
- Technology less suited to some groups i.e. elderly and frail, those with poor sight, people with learning or physical difficulties and young children though devices can be adapted with images and larger font etc.
- Where assistance is provided to complete the survey, respondent loses anonymity
- Mostly quantitative responses with some provision for free text

Kiosks

A kiosk is a stand-alone touch screen device which is larger than a PDA. They are usually static within a location and can be either wall mounted or floor mounted.

Pros

- Completion of survey is anonymous
- Sample is self-selected
- Generally user-friendly
- Number of questions variable



Cons

- Certain groups i.e. the less technically literate are less likely to use them
- Kiosks are often not visible enough, their purpose is not explained and no assistance is offered or use encouraged by clinicians or other members of staff
- Use will depend on location and functionality
- Time pressures may prevent people from using them
- Kiosks can be vulnerable to misuse with people entering multiple responses
- Largely quantitative data collected
- Often the extremes of opinion provided by these methods

Bedside terminals

Feedback in hospital environments can be provided via bedside television units i.e. systems such as Patientline. These units normally provide a personal phone and in some instances provide access to the internet and email.

Pros

- Could overcome sampling issues as self-selected
- Could complete through touch screen or telephone and where keyboard and internet connection provided – online
- Could provide incentives for completion, such as credit to use terminals



Cons

- Quantitative data in the main but where keyboard provided could allow for some free text
- Ability to use mobile phones on wards may affect future use of bedside units



Telephone interviewing

Telephone interviewing may take the form of either a self-administered questionnaire using the phone keypad and automatic voice prompts or a questionnaire administered by an interviewer. Interviews may be pre-arranged or calls made opportunistically. Cold calling using random digit dialling is more likely to be used for soliciting general views and opinions rather than specific experiences of healthcare.

Pros

- Response rates can be higher for pre-arranged calls rather than opportunistic calls
- Pre-arranged calls viewed as a convenient method
- Computer Assisted Telephone Interviewing results in reduced data errors, speedy analysis of responses and is cost-effective
- Detailed responses can be provided when an interviewer is used but more costly and can produce 'moderating results'

Cons

- Low response rates for random digit dialling methods, and opportunistic follow-up calls
- Random digit dialling methods and opportunistic follow-up calls may be viewed as intrusive
- Questionnaires are shorter and therefore less opportunity for detailed responses with Computer Assisted Telephone Interviewing
- Lack of universal coverage for telephone ownership

Case Study

One West Midlands based PCT is using a telephone system for people with long-term conditions. The system provides support to people through advice and guidance but also provides people with the opportunity to provide feedback on their experiences. The PCT is currently looking to develop a similar system for other patient groups.

Fact

Home, landline or terrestrial telephone ownership is decreasing in favour of mobile coverage. According to studies, 13% of adults over 15 have no fixed line phone and 7% of households have no phone or mobile at all. Younger households are most likely to have a mobile only. (Blyth 2008 and Duffy et al 2005)



Online Questionnaires

Online methods may require a respondent to complete a computerised questionnaire which is either emailed directly or posted on the organisation's website. An organisation's own website can also provide people with the opportunity to leave general feedback through computerised feedback or comment forms, or to give their views on specific issues through 'voting' buttons.

Informal patient and service user feedback is also available on a range of other websites which are non organisation-specific. NHS Choices and Patient Opinion websites both provide people with the facility to feedback comments in the form of ratings and free text on any aspect of care they or their relatives have received. These comments are available to NHS organisations and can provide a rich source of data.

In addition to these specific websites, a great deal of healthcare related dialogue occurs on social networking and media internet sites. New mothers for example may write about their experiences of giving birth on a variety of forums such as www.newmums.com. Organisations could tap into this additional source of potentially rich data, though it would require investment in the IT systems and resources to do so.

Pros

- Self-administered online questionnaires result in higher reporting of sensitive information
- Allows for more complex structures – question branching, routing etc. and use of graphics and other visuals
- Ability to gather a lot of data in a short time. The ease, convenience and speed of using a website appeals to many
- Website would provide people with the opportunity to leave feedback anonymously and avoid direct contact with people if they so wished

Cons

- Will not generate high responses among those where trust or understanding of technology is low
- Internet coverage not universal
- Respondent fatigue more evident – 18 minute drop off point

Fact

65% of UK households have home internet access (Office for National Statistics, 2008) but figures suggest that in total only 35% of over 55s use the internet.

Internet access is significantly lower among people who are older, less affluent, who have poorer health, and who have no formal qualifications.

Top tip

Contacting patients and service users after a care episode by phone or email in order to conduct a survey can raise difficulties as numbers (whether land line or mobile) and email addresses are not universally collected. Changing the contact details that are collected can increase the options for gathering feedback.



Online communities and member's panels

Another method gaining popularity is online communities. These are groups of people whose members communicate with each other electronically – similar to social networking but established for the specific purpose of gathering feedback and opinion on a particular theme or topic. They are well suited to disease specific groups such as people with a long-term condition like diabetes, or groups such as new parents.

Members' panels are an additional method of generating opinions, views and feedback from often large groups of people. Membership is dependent on a general relationship with an organisation, rather than a specific interest or concern.

Pros

- Online communities are useful for collecting quantitative data
- Quantitative polls can be run through online communities when required
- Large amounts of information can be generated in a short time

Cons

- Building online communities is difficult and initially time consuming
- Online communities require expertise to regularly monitor, moderate and maintain i.e. keeping membership updated

Case studies

One West Midlands based PCT is currently testing out on-line communities for condition-related networks i.e. diabetes, in order for people to engage with each other and health professionals.

A PCT outside of the West Midlands has set up a panel of 500 local people which is being used to sound people out on a variety of issues. A two-page questionnaire is sent out each month and participants receive £50 if they respond to 11 out of 12 surveys a year. So far, the response rate is 70%. Participants have recently commented on the PCT's commissioning strategy and strategic plans. Feedback is used to evidence business plan proposals put forward to the PCT Board.



7.0 Using feedback

Seven steps to success

To ensure effective use of feedback, organisations need to develop a formal strategy and robust processes for the following stages:

- Collection
- Collation and storage
- Interpretation and analysis
- Reporting and dissemination
- Taking action
- Monitoring and evaluation
- Feeding back

For services provided across organisational boundaries, this should include the development of a Joint approach with Local Authorities and other agencies.

Collection

This has been covered in previous sections of the guide.

Collation and storage

In order to develop a more systematic approach to managing feedback it will be necessary to bring together data from a variety of sources and in a variety of formats. These might include the following; results of questionnaires and surveys, feedback from focus groups and informal patient contacts, comments from NHS Choices and Patient Opinion websites, PALS contacts, complaints, clinical outcomes and patient reported outcome measures (PROMS).

It is likely that organisations will need to consider the development of a bespoke system to store and manage the data it gathers.

Interpretation and analysis

Interpreting and analysing information, often from a variety of sources, will require organisations to provide capacity and to invest in specific skills. Turning feedback into action requires interpretive competency and effort.

Quantitative feedback from questionnaires may be more useful at a strategic level to measure trends and to assist in planning where the organisation's focus should be i.e. improving cleanliness, staff attitude, communication etc.

Qualitative data, such as patient stories, or initiatives such as Experience-Based Design (see section on taking a person-centred approach) can provide rich enough information to determine why issues have arisen and in some cases suggestions as to how to put things right.

Reporting and dissemination

An organisation's dissemination strategy is one of the most important aspects in effective use of feedback. Feedback is often more effective when the findings are disseminated in tandem with educational programmes or quality improvement guidance.

Providing the results of surveys and subsequent actions taken to staff, and providing staff with the opportunities to review this information, is as critical as providing it to patients and members of the public. Examples of good practice in dissemination include: directorate management teams to discuss action plans; staff volunteers recruited to working groups to undertake specific improvement initiatives; posters in staff areas; articles in staff bulletins and posting the results of surveys and consequent actions taken on websites and intranets.

Taking action

The use of feedback is enhanced when the information collected is easily actionable. For feedback to be of maximum effectiveness in terms of service and quality improvement, organisations should be experienced in quality improvement processes and will need the capacity and skills to translate feedback into actions. Patient satisfaction questionnaires and surveys do not in themselves indicate the course of action to take as they rarely provide recommendations; so while they can pinpoint problems, they can't identify root causes.

Feedback can be used effectively to support service planning and decision-making i.e. surveys asking 'trade off' questions for annual Local Delivery Plan (LDP) rounds or polling to rate health services or to gain the public's views on how funds should be spent. Feedback from patients, service users and members of the public might also be used to support business plans for specific developments.

However, organisations should bear in mind that people may not always share the same priorities

and values when it comes to making decisions i.e. the funding of services. The public may place more value than commissioners for example on reducing mortality and investing in life-saving interventions rather than interventions to reduce morbidity, such as smoking cessation services.

Top tip

Senior executives must lead by example. If the Board does not show how it takes patient views into account in its decisions, then it is unrealistic to expect front-line staff to do this in their own work.

Organisations should also consider what a significant response rate would be in order for it to take action and invest in making changes - if one person makes a comment, if 10 people make the same comment, if 50 make the same comment? Will it be the magnitude of the issue raised rather than the number of times the same issue is raised that counts or something else?

Monitoring and evaluation

Where action has been taken as a result of feedback received, organisations should not forget to check with patients or service users whether the change has had the desired result and that services are consequently better in the patient or service user's own terms.

Feeding back

The 'You said, we did' aspect of engagement is often missed out by organisations, not because they haven't made any change as a result of people's feedback but because not enough thought goes into this last but critical element.

Increasing apathy among people towards providing feedback can be caused by the fact that many people do not believe their feedback will have any effect. Publicising the use of feedback helps build trust by showing people's views are taken seriously. It also helps to create a dialogue with the community.

Factors that can hamper the effective use of patient feedback

Organisational barriers

- Lack of supporting values
- Competing priorities
- Lack of quality improvement infrastructure

Professional barriers

- Clinical scepticism
- Defensiveness and resistance to change
- Recruitment of staff against a skill set too focused on technical rather than interpersonal skills

Data related barriers

- Lack of expertise to analyse and interpret
- Lack of timely feedback
- Lack of specificity of data obtained
- Samples which are unrepresentative
- Uncertainty over effective interventions
- Cost effectiveness of infrastructure to support process

To overcome these barriers

- Develop a patient centred approach
- Create a structured process for quality improvement
- Develop a coherent involvement strategy and clear action plans
- Build a system of clinical leadership for improvement
- Ensure senior commitment and leadership
- Adopt organisational development principles
- Feedback to, and involve staff
- Work with human responses to change
- Properly resource and support activity
- Develop clear roles and responsibilities
- State a commitment to partnership working, equalities and diversity
- Ensure effective mechanisms for evaluation and sharing the learning

The effective use of feedback will inevitably result in change at some point and at some level within an organisation. People's responses to change are varied, and neither simple nor predictable. Some people embrace change as challenges, opportunities or something new and exciting. Others may experience feelings of uncertainty, insecurity and anxiety.

If the feelings people experience about change are not identified and worked with effectively people can become defensive and aggressive. There may be a fall in morale and job satisfaction and conflict can become more difficult to resolve. Ignoring, denying or avoiding addressing people's responses to change will negatively impact on the change effort.



Top tip

Using ordinary leaders and champions

Use formal and informal leaders, teams and groups to support improvement as part of everyday work. Identify and encourage a variety of champions including 'ordinary leaders' to institutionalise improvement and reduce dependence on senior managers, who may often be transitory.

Ordinary leaders can be people in any grade of job i.e. medical secretaries, Health Care Assistants, receptionists etc. They know the organisation, its processes and its people inside out. They can be blockers to change but if their energy is harnessed they can be the greatest advocates and drivers of change.

Involving doctors is also one of the most important and necessary factors for success. Managers need to identify clinical leaders and the communication networks to which they belong, and actively influence them and gain their support. They also need to provide the time, resources, incentives, data and evidence of results to convince doctors to be involved.



8.0

Integrating feedback into the commissioning cycle

The Department of Health has developed and launched a PowerPoint pack (DH 2009c) outlining a conceptual model which allows organisations to understand how Patient and Public Engagement fit with commissioning. The Engagement Cycle, developed on behalf of the DH by InHealth Associates, describes (and provides checklists for) five key Patient and Public Engagement (PPE) activities across the three main stages of commissioning as follows:

1. Engaging communities to identify health needs and aspirations
2. Engaging with the public (as citizens) in decisions about strategies and priorities
3. Engaging patients in service design and improvement
4. Patient-centred procurement and contracting
5. Patient-centred monitoring and performance management

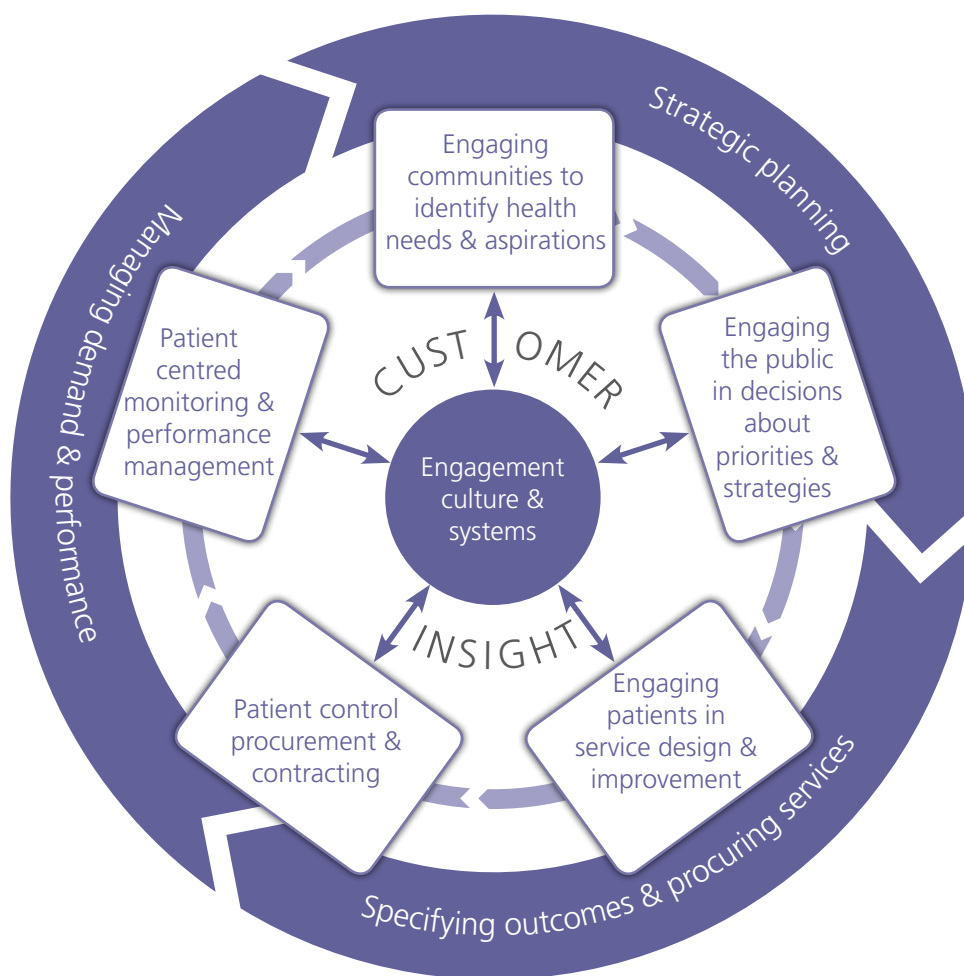


Figure 4: The Engagement Cycle
Source: Department of Health and InHealth Associates

At each of the different stages of the cycle, there are different purposes to engagement, different stakeholders involved and different approaches required i.e. identifying health aspirations with communities is different to public engagement with citizens (as taxpayers) in prioritisation decisions, where accountability is key. Patient engagement in service planning and improvement work brings in another set of stakeholders.

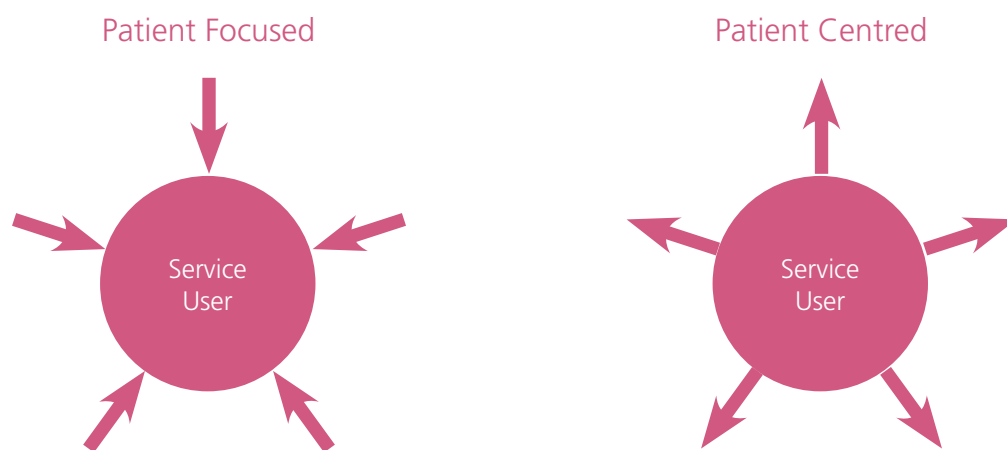
Engagement in identifying health aspirations and decisions on priorities are often corporate-led activities and can involve a multi-agency approach. Patient engagement meanwhile is often at the service or patient pathway level. Though many methods of PPE can be adapted for multiple purposes, some may be more useful at particular stages i.e. community development approaches to identify health aspirations or deliberative events for priority setting.





9.0

Taking a person centred approach



A patient-centred approach means to work alongside users and support them to articulate their experience, and involve them in making the change i.e. Experienced Based Design. This compares to a patient or person focused approach which means consulting patients about what they want and then taking action. Within a person-centred framework, the focus for change shifts from change to improvement and from process to outcomes, ultimately to lead to a better experience for service users and patients.

This approach requires a focus on co-production between the organisation and staff (internal) and the user and stakeholders (external). Bringing staff and patients together on a regular basis to share stories, listen to each other, and work on creating solutions together, provides the impetus for mobilizing change beyond commitment and engagement.



10.0 Conclusion

Getting feedback at the right time – not necessarily in real-time – is the key issue, together with the effective use of feedback to bring about change. For long term strategic purposes, the timing of data collection is not necessarily as important as ensuring data is collected on an ongoing basis from a representative sample of the population and that this is used systematically and according to a clearly defined strategy.

Commissioners and Provider Trusts need to work together with service users and citizens to bring patient experience and needs directly into the commissioning process. In addition, healthcare organisations should be exploring partnerships with local authorities to develop common systems and technologies at population levels. To do this, commissioners need to be able to work effectively across organisational boundaries, building relationships and networks that will work for the whole system.

Organisations should involve patients and the public in determining what is important to them, based on their experience of using services. Organisations must ensure they are asking the right evaluation questions, determined by user need and experience. Public education on healthcare matters before soliciting views and opinions is one way of engaging local citizens and patients in a potentially more meaningful dialogue.

Organisations should develop the skills and behaviours to focus on co-production between

the organisation and its staff and the user. Staff will need to develop their knowledge, skills and expertise in designing services, not only to be functional and work well, but crucially, to also be a good experience for service users on their own terms.

The development of new technology is providing innovative and enabling ways in which health and social care can be more person-centred, responsive and improve the quality of care. However, there is a danger that technological solutions will become a proxy for human contact. Highest on the list of complaints from patients about their care is how they are treated by people, with a lack of respect and dignity cited as key issues. Embedded in a lack of respect or dignity is the lack of relatedness.

Technology has an important part to play, but its introduction needs to be thought through carefully to ensure that those providing direct care for patients don't see themselves just as suppliers to a customer.

11.0 Appendix A – Suitability of methodology with given criteria

Criteria	Face-to-face		Paper-based		Handheld Devices (PDAs)	Touch screen kiosks	Bedside terminals	Telephone interviewing				Online methodologies			
	Focus group	Patient stories	Self administered Questionnaire	Comment cards				Random digit dialling	Opportunistic follow-up	Prearranged follow up	Computer assisted telephone interviewing (voice activated)	Online questionnaires	Organisational web-sites	Online communities	External websites i.e. Patient Opinion and NHS Choices
Volume response			✓✓		✓✓					✓✓		✓✓		✓✓	
Quantitative Data			✓✓		✓✓		✓✓				✓✓	✓✓	✓✓		
Qualitative Data	✓✓	✓✓	✓	✓✓					✓	✓		✓	✓	✓✓	✓✓
Speed					✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓		✓✓	
Low Cost			✓✓	✓✓				✓	✓✓	✓✓	✓	✓✓	✓✓		✓✓
Inclusivity	✓✓	✓✓			✓			✓							
User-friendly	✓✓	✓✓	✓✓	✓✓	✓	✓				✓✓					
Reporting of sensitive information		✓	✓✓								✓	✓✓			

Suitability is expressed as either high ✓✓ or limited ✓ based on available evidence. Where evidence was not available, no assumptions have been made

12.0 Appendix B – Suitability of methodology with given client group

Client group	Face-to-face	Paper-based	Hand-held Devices (PDAs)	Touch screen kiosks	Telephone interviewing		Online methodologies				External websites i.e. Patient Opinion and NHS Choices
	Patient stories	Postal questionnaire			Landline	Mobile	Online questionnaires	Organisational web-sites	Online communities		
Older People	✓✓	✓✓	✗	✗			✗	✗	✗		✗
Young People	✓✓				✗		✓✓		✓✓		
Men									✓✓		
Women									✓		
Young Children	✓✓		✗	✗							
BME Communities		✗✗									
Affluent, Well educated							✓		✓		
Less well educated		✓✓									
Socially disadvantaged	✓✓				✗✗	✗✗	✗✗	✗✗	✗✗		✗✗
Physically Disabled	✓✓		✗	✗							
Learning Disabled	✓✓	✗✗	✗	✗							

Suitability is expressed as either high ✓✓ or limited ✓ or low ✗ or very low ✗✗ based on available evidence. Where evidence was not available, no assumptions have been made

Appendix C - International, public and industry sector examples

International Healthcare Organisations

- **Planned Parenthood Mohawk Hudson (US)**
Wanted direct patient feedback but a paper survey was considered inconsistent and not eco-friendly. Currently use touch screen kiosk devices in largest clinic sites in waiting rooms to gauge patient satisfaction as well as informing patients of special programmes available to them. Data collected is being used to evaluate quality of care, convenient hours for patients, and level of customer service.
- **Saint Francis Heart Hospital (US)**
Random sample of discharged patients surveyed each week by telephone. Survey results presented monthly to staff and management.
- **Melbourne Health Consumer Panel**
Community Relations Team 039342 7760 consumers@mh.org.au. 35 people on panel – focus groups, projects and committees. Panel members involved in development of organisation's service plan (both acute and community organisation).

Other public sector

- **Southampton City Council, Leisure Services**
Existing comment card and website methodologies generating limited responses, which were difficult to quantify. Touch screen devices placed at 'point of service' areas in art galleries, museums, tourist information centres, libraries etc. Also using to recruit customers who 'fit the profile' for Customer Focus Groups.
- **Hertfordshire County Council**
Programme of improving customer feedback – vox pops filming, mystery shopping, touch screen interactive questionnaires.
- **Nottingham County Council**
Website feedback, traffic light smileys on each page. Visitors to website rate about 2,000 pages each month – nearly 60% rates as good but 30% as poor. Provides some examples of how services have changed based on feedback.

Industry and private sector

- **The Mandarin Oriental Hotel**
Management receive daily updates on each new guest. Each customer has a profile with preferences which is kept and updated.

- **Radisson Hotels** – 155 hotels
According to website, the Group provides a 100% guest satisfaction guarantee. Feedback form is available for guests to complete on website.
- **Ibis Hotels** – 700 hotels
Provides a quality commitment (published on website) – if a guest experiences a problem, hotel will resolve it to guest's satisfaction within 15 minutes, or the room is free. Also comments form available on website.
- **London Underground**
Stations required to undertake surveys at stations as part of Secure Station Scheme run by Department for Transport. Previously used face-to-face interviews but costly and timely. Touch screen device attaches to existing customer information whiteboards. Generated approx 700 responses per fortnight. Surveys cost approx 30p per response. Surveys measure feedback on local and tactical issues.
- **ASDA**
First phase - touchscreen devices in 100 stores. Now have a mobile van with touch screen devices installed, which goes round stores.
- **Specsavers**
200 touchscreen devices which company rotates every four months through its 650 stores. Different language surveys on devices, respondent chooses preferred language on entry screen.
- **Cadbury World**
Wanted substantial amounts of feedback to put together 'customer profiles' based on geographical location and age. With results planned to pinpoint improvements and changes to advertising. Previous face-to-face survey, lengthy and costly and only 200 respondents. Use touch screen devices and gather 700 responses a week – has halved research costs. Led to better understanding of customer and has re-focused their advertising strategy. Survey pinpointed products and activities customers want which has enabled them to re-focus merchandising too.

14.0

Acknowledgements

devices placed in entrance halls and waiting areas at 6 police stations for 10 days at each site. Survey to collect opinion on the service and environment. Devices also put in local retail stores to gather community attitudes to policing. Each station gathered approx 100 responses over 10-day period. Placements in supermarkets gathered higher response rate.

- **John Lewis**

Well established Mystery Shopper Programme.

- **ARGOS**

Using touch screen devices for real-time satisfaction surveys. Devices placed in 140 stores from December '08. Plans to place them in all 700 stores between March and September '09. Also supplements with an online survey.

- **Boots**

Additional receipt handed to shopper with purchases, providing an email address and telephone number to call to complete a customer satisfaction survey. Unique code on receipt to be able to enter survey – opportunities to win a prize by completing.

- **CITIBANK**

Uses multi-mode survey since 2006 – touch screen kiosks, telephone and internet. Initially in 1,500 branches of bank in US and now in UK and 12 other countries – over 1700 locations and 1.08 million responses to date.

- **Royal Mail website**

Pop up box asking whether user will complete a questionnaire after using website. Multiple choice questions – about a dozen – with some free text.

- **Mail Online**

Pop up box asking whether user will complete a survey re: their use of website and other media. Takes 8 minutes to complete and entered into a draw (10 Amazon or M&S £50 vouchers to win).

- **B&Q**

Surveys on website usage and user opinion, feedback on specific products and post sales surveys on customer satisfaction.

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Appendix D – Useful Resources

InHealth Associates are patient-centred management consultants who provide advice and support for NHS and Third Sector organisations, focusing on what matters to patients. InHealth Associates promotes the involvement of patients and the public in everyday healthcare practice. The consultancy runs one-off workshops, conducts presentations and seminars, undertakes research and provides strategic advice, organisational development and leadership support.
www.inhealthassociates.co.uk

National Centre for Involvement (NCI) – *Key principles of effective Patient and Public Involvement* (2007)

NHS Institute for Innovation and Improvement – *Improvement leaders guide to involving patients and carers* (2005)

Pickier Institute Europe works with patients, professionals and policy makers to promote understanding of the patient's perspective at all levels of healthcare policy and practice.
www.pickiereurope.org

Sandwell Primary Care Trust – Engagement Toolkit www.sandwell-pct.nhs.uk

Signposts – A practical guide to public and patient involvement in Wales
<http://wales.gov.uk/docrepos/40382/dhss/reportsenglish/signposts-e.pdf?lang=en>

Thinkpublic are an award-winning agency focused on using design to improve service experiences in the public sector (Experience Based Design – EBD). They achieve this by working with service providers and the general public to gain understanding of how services and experiences could be improved. Thinkpublic has worked with the NHS, education, Local Government and the Third Sector.
www.thinkpublic.com

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